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Migration and Mental Health*

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I am really grateful to be here and particularly grateful for this invitation for two reasons. One, Professor Yap was a pioneer, particularly in cultural psychiatry. The work he did on culture-bound syndromes and psychiatry in Hong Kong was classic. Secondly, it's always a great pleasure to be in Hong Kong, and any excuse to extend my stay is always welcome. That says something about me and my migratory patterns.

What I want to do is to go over some of the issues of migration, what migration means and how people are affected by it. Then I will use two studies and two psychiatric conditions to explore some of the impact that migration has, not only on individuals when they are migrating but also on their families and what that does to their mental health.

What is Migration?

Migration is a fairly heterogeneous process. People migrate for all kinds of reasons, all kinds of distances, all kinds of ages. There are lots of definitions of being a migrant. There is a legal definition – if you are an asylum-seeker or not. The law will determine if you're allowed in or not, whether you need a visa before you go or whether you just show up and hopefully somebody will allow you in. The law says a migrant is somebody who changes their place of residence for any purpose or for any period of time. Now that is a marginally difficult definition because how do you define the purpose and how do you define the duration? Are we talking about two days, 2 years or 20 years? Similarly, are we talking about migrating for education, economic reasons, medical reasons, etc.?

When we start looking at the impact of migration on people's mental health, two things we have to bear in mind. One is the characteristic of that particular migration. Certainly when I was growing up in India in the 1960s, a lot of people migrated to America at that particular point. The American consulate or embassy in Delhi used to have training courses for people who were migrating. You had to go and spend five days in Delhi to learn about America, about American culture, and the weather, and the kind of clothes you were going to take.

What that indicates is that there is an element of preparation that people have to go through and what that means in terms of their response. And that also links with the motivation for migration, whether you go for education or you go temporarily to get your degree and then you decide that I really like it here and I don't want to go back, or I'm really fed up and I want to go back as soon as I can.

There are various reasons as to why people migrate. Occupation reasons are rather deliberately put, anthropologists at the top of the list because anthropologists migrate to look into other people's culture, to look into other people's psyche and to look into other people's behaviours. And then diplomats move every so often, every three years they come back and then they move to some other country for three years. People will go for higher education as well. Then journalists move quite regularly. People who are in military service quite often will be posted abroad, especially in certain countries and certain settings. Then you have missionaries who move regularly, and salespeople and people who have seasonal migratory work.

The message from occupational migration is that these individuals are going to have different kinds of stresses. They don't have the same kinds of stresses as people who may be running away for political reasons, people seeking asylum, or people going through the process of illegal migration, an escape scenario or a similar situation.

Another thing worth bearing in mind is the pattern of migration because the stress of that type of migration will be very different depending on where you are migrating from and where you are migrating to. If you are migrating across countries, then there are specific issues. It may be that if you are migrating from Country A to Country B, and you may have to learn a whole new language. That means not only do you have to learn a whole new language, but also you have to get used to the weather, need a different set of clothes, need to understand what the social norms are, whether you shake hands, what the interpersonal distances are in terms of communicating with people. In some cultures, it is very clear you can be very close and it's not seen as a threat or seen as intrusion. I think that is part of the stresses migrants have to go through.

The second pattern of migration is within a country, especially when you are moving from a rural area to an urban area or from an urban area to a rural area for various reasons. It also means that with industrialization and globalization, there are different expectations and there are different stresses that people go through.

People migrate for political reasons, for economic reasons for betterment for themselves or their families or for social reasons. That may be transient, that you go to sell your product or go to buy a particular product. Even for an economic reason, people may migrate for a permanent stay rather than a temporary one.

For migration, people either move singularly or they move in groups. When they move in groups, there may be other stresses, and if they move singularly, there may be different stresses. One of the key migratory patterns in the U.K. in the 1950s and 1960s was that with the world war ending, there was a need for labour to provide services. The story goes that there was a retired army sergeant who was sent to India and Pakistan to recruit people. He went to villages where he knew soldiers had come from, so whole villages effectively migrated together. When they settled down in the U.K., they settled down as if they were settling in villages, they went to the same factory, they spoke the same language and they hardly ever integrated with the larger population. I think that raises some very interesting questions and I'll come back to that.

Similarly, if you're moving as students, there are different kinds of stresses. You have aspirations that you have to achieve, and if you don't achieve them, there is something wrong with you.

I have to mention stars, in this case film stars and pop stars, who quite regularly move. There are stars who have a beach house in Malibu and a chalet in Switzerland or a manor house in England. Their migratory stresses are going to be quite different if they have any

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stress at all. If they are going in private jets, they don't have to worry about queueing up to take a flight. They can board when they want to. They can land when they want.

Stress of migration is also going to be dependent upon the age of the migrant, the gender, and whether they are a primary migrant or a secondary migrant. A primary migrant is the first person in the family to migrate. Others will follow and stresses may be different because a lot of the stresses the primary migrant went through would have been sorted out, for example, maybe accommodation, maybe transport, maybe money. Therefore, adjustment patterns would be quite different. Depending on the educational patterns, if you are well-educated, obviously the stress patterns will be quite different. When you migrate and you're educated in medicine or law or one of the professions, what do you do? If you can't practice law, does it make you feel better or worse? That would depend on what your expectations were.

I remember once in Copenhagen I was riding in a taxi from my hotel to a conference place. As it turned out, the driver was a Pakistani chap, so we got chatting in Punjabi, nattering away about how long he'd been there and what he'd been doing. At the traffic lights the taxi stopped and another taxi stopped next to it. The driver lowered the window and chatted with the other driver. The lights changed and I asked him, "Who was that?" He said, "Oh, that's my cousin. Unlike us, he's a lawyer." I said, "What do you mean he's a lawyer?" He said, "Because he can't work in Denmark in law, he's driving a taxi." You can imagine the kind of stress that could be caused to somebody who spent four or five years learning a profession and then, hoping to achieve more, migrating and getting there and not being able to do that. Obviously, whether you migrate voluntarily or you're forced to, there is going to be different stress.

The question often asked is "What predisposes people to migrate?" Is it something in the personality? There is another question – especially when we look at the rates of schizophrenia and how they are higher among migrants – "Is there some kind of predisposition which is producing an urge to migrate and also schizophrenia?" We know that in some migrant groups there are low rates of mental disorders following migration. Is the pattern adjusted or is it not recognized because conditions are not very good for assessing people from other cultures in various languages and other behaviours? Is it that there is a kind of selective migratory pattern which will lead to some kind of specific stress?

When people migrate they may react to the process. Some people become very enthusiastic and become more British than Britishers themselves, changing their language, changing their accents and changing their clothes. The whole process of culturalisation becomes overwhelming and they cannot deal with it in their context. They may deny difficulties. On the other hand, some people become very critical. Others may become very inhibited and cannot publicly acknowledge that they made a mistake by migrating. But they cannot go back either, so the tension creates a problem. The question really is whether that response is a kind of depressive response or not. On the other hand, there is a kind of hyperactive response where people become very labile and act out.

John Berry has talked about responses divided into three different kinds. Adjustment, where people find a happy medium. He settles down into what is called bi-culturalism. You can work out what are the good things in each culture. You try to deal with that in that particular way. Or you react in a very reactive way which may be positive or may be negative. Or you withdraw completely.

Khoa and Van Deusen talked about reactions to migration. Again, three kinds of things. You either give up your culture completely and lose your identity and adopt the new one because you think that that is the only way you're going to be able to progress. But others will feel very comfortable in their culture rootedness, that this is my culture. This is who I am. This is my language. This is my tradition. But I can also do things according to the new culture, new norms and new parameters. You become very bi-cultural.

The stages of migration are pretty clear, in terms of pre-migration, migration and post-migration. Pre-migration is, you could argue, a life event. Post-migration, you adjust to it. The stresses at each level are quite different. They are going to be determined by the individual personalities, the reasons for migration, and so on and so forth.

Experiences before, during and after arrival, produce stress whether you migrated alone or in a group. Initial expectations and intentions towards the new country and culture and equally the attitude of the new country towards you may influence how welcome you feel and how distressed you feel, whether you've migrated before and had similar experiences and how you can learn from that and what that means. This is again just to emphasize the heterogeneity of migration, that there may be a relationship between nature and man, a kind of ecological push. If people are leaving Zimbabwe, that's a different kind of migratory experience than if people are moving from the U.K. to Australia or Australia to America. Whether it is migration policy, aspirations of social momentum, migration would be either primitive or free of mass migration and whether it would lead to displacement, flight or settlement. Again, that would depend upon your organisation and whether you see yourself as a pioneer and whether you're moving to do something different, to do something new. The first person in the family to migrate is always seen as a pioneer and expectations are much greater.

I've already alluded to achievement, that is expectation. If you're expecting that you'll migrate to the UK and become President of the Royal College of Psychiatrists, it ain't going to happen. How it happened to me is a different story. So the expectation is that I may have aspiration for myself, for my children, for my family. If they don't match that, then the stress and depression become much stronger.

Studies on Migration

The classic study was done in 1932 by Ødegaard, who looked at Norwegians who migrated to America and Norwegians who stayed back in Norway. He showed that Norwegians who migrated to America showed 30-50% higher morbidity in psychiatric terms compared to Norwegians who hadn't migrated. He also found that admissions due to schizophrenia were consistently higher but only 11% presented within the first two years of migration while 50% presented within the next two years or more. That means it is not necessarily stress of migration that is causing the problems. If it is causing the problem, it is only causing the problem in 1/10 of the people. Half the people are experiencing problems 10 years after migration. That indicates either the process is something different or it's a different kind of stress.

Over the last 50 plus years, there have been a series of studies in the U.K. looking at rates of schizophrenia among African-Caribbean migrants and U.K. natives. Table 1 summarized the findings of various studies.

Table 1

UK African Caribbean Immigrants and UK Natives Incidence Rates per 1000 for Schizophrenia

Study	Location	Diagnosis	Age Std	UK Natives	UK African Caribbeans	Ratio
Hemsi 1967	Camberwell + Lambeth	Own from case notes	+	2.7	13.1	4.9
Cochrane 1977	England + Wales	Mental Health Enquiry	0	*M 8.7 *F 8.7	29.0 32.3	3.3 3.7
Cochrane + Bal 1987	England + Wales	Mental Health Enquiry	+	M 1.2 F 1.2	3.9 3.3	3.3 2.8
Carpenter + Brockington 1980	Manchester	Hospital	+	2.0	11.1	5.6
Dean et al. 1981	SE England	Own from assessment	+	M 1.1 F 1.0	5.5 5.3	5.0 5.3
Littlewood + Lipsedge 1981	Hackney	Own from case notes	+	1.9	4.5	2.4
McGovern + Cope 1987	Birmingham	Hospital	+	Age 16-29 1.4 30-64 1.1	11.7 4.7	8.4 4.3
Harrison et al 1988	Nottingham	Own from assessment	+	16-29 2.0 30-44 1.6	29.1 19.7	14.6 12.3
King et al 1994	North London	Own from assessment	+	2.0	8.9	4.4
Bhugra et al 1995	West and South London	Own from PSE assessment	+	2.96	6.88	2.2

* Prevalence Rate

There is a classic study that Cochrane and Bal did in 1987. They looked at admissions across the whole of England. There is a central database where every admission and details are kept. They looked at the data and looked at ethnicity. Not ethnicity per se but what they were looking at was where the patient was born. They found that the rates of admission for schizophrenia in the U.K. were higher for the Irish, Indians and Pakistanis and Caribbean-born compared to the native British. In general the foreign-born had and continue to have higher rates of admission, except for Pakistani women. That is a very interesting observation because it became very clear that a lot of Pakistani women, especially the young age when schizophrenia occurs, likely got married off and were sent back to Pakistan.

In 1981, they looked at basically 186,000 admissions and looked at country of birth, marital status, diagnosis, first admission, age,

region they came from and gender. The results are not ethnicity-based but country-of-birth based. So if you were white and born in India or Pakistan, you were counted as Indian. There is a problem about how you carry out research across cultures, across different ethnicities and how you define race, ethnicity, culture and how do you identify schizophrenia.

Major findings were that rates of first admissions were more than twice in Irish-born. That is an absolutely fascinating finding for several reasons because Irish can get to the U.K. by ferry which takes about five or six hours, by flight which takes about 50 minutes, speak the same language, and a lot of cultural norms are very very similar. So why is it that these rates are higher? They also found that the rates of first admission were lower in Asian groups and slightly lower for African-Caribbean females but slightly higher for African-Caribbean males. The Irish born and African-Caribbeans of both sexes have very high rates for first admission and readmission when compared with English-born. Indian-born males rated only slightly higher and Indian females conspicuously higher for schizophrenia. Pakistani born males have double the native first admission rates but Pakistani females show 33% excess over natives in first admission but have lower readmission rates. A relatively high rate of admission for schizophrenia as a proportion of admission for all diagnoses is typical of immigrants to Britain. It's an old study but these findings are still true.

One of the difficulties when we are looking at rates of any disorder is how do you define what the denominator is of the group you are looking at? In the two national surveys of the population census people have either not given their ethnicity or they've written other things which cannot be counted. These are some of the problems to be thinking about on cultural factors in diagnoses and cultural factors as part of overall studies.

The Case of Schizophrenia

Obviously existing problems have to do with psychological pressures and psychological vulnerability. They came up with a series of hypotheses to explain why the rates of schizophrenia might be higher. The first one was misdiagnosis, that the clinicians cannot really diagnose schizophrenia in people from other cultures. To some degree they don't understand what the cultural significance of hearing voices is. In some religions talking in tongues is quite common and it's not pathological. Similarly there is some evidence to say that because of linguistic differences we tend to under-diagnose or over-diagnose. An interesting finding is that quite recently there have been a couple of studies which have indicated that rates of depression go up among migrants when migrants start to speak English. Is it because switching to English you can express yourself better or you can use terms like, "I feel depressed", whereas in lots of languages there is no word which describes depression?

The second one was called 'ethnic liability'. Are some ethnicities more prone to schizophrenia? Probably not when you look at rates of schizophrenia among African-Caribbeans in the Caribbean . Two studies I was involved in in Barbados and in Trinidad indicate that the rate of schizophrenia among Caribbeans in the Caribbean are the same as the native British in Britain. Obviously something happens to people when they migrate. Is it because you're kind of restless and you have a schizophrenic-type personality and therefore you want to migrate and then you become ill? Highly unlikely, because perhaps from Ireland it is fairly easy, you don't need a visa, you can just get on a ship. But if

you are migrating from India or Pakistan or Bangladesh or the Caribbean where you may have to go and queue for a day or two to the British embassy to try to get your visa, you need to be fairly solid and mentally healthy to be able to go through that process.

Another hypothesis which was put forward was that it has to do with stressful complications. Neuro-development causes can produce schizophrenia of tragic complications and there is a correlation. Robert Murray and Peter Jones did some work in South London about 15 years ago which indicated high rates of stress complications which lead to high rates of schizophrenia. With the stress of migration again the difficulty is, if you bear in mind what I already said about Odegaard's work, what is happening ten years after migration, is it likely that the stress of migration is causing high rates of schizophrenia? If it is stress, why is it not causing anxiety or depression? Why is it causing schizophrenia?

There is clear evidence that cannabis causes schizophrenia, and there is a lot of cannabis consumed among African-Caribbeans in the U.K. That in itself is a problematic hypothesis that unless you know how many people in the population smoke cannabis, you can't really say that cannabis and schizophrenia are related. You need to know if 100 people smoke cannabis in the population and one person develops schizophrenia, what about the other 99 who haven't developed schizophrenia on cannabis? How are they protected? There is some interesting work coming out of New Zealand that indicates there are some genetic differences in people who respond in abnormal ways to cannabis. Is it stress or social and economic disadvantage? Is it a social economic disadvantage that you are starting to explain that you're worried about not having a job, not having friends and smoking cannabis? In an odd way, you are starting to develop these voices which keep you company, so it's a kind of social development or psychosis. We know in terms of misdiagnosis that firstly these were research diagnosis. These were not necessarily clinical diagnosis and earlier case-based studies.

Schizophrenia is a difficult diagnosis. There are diagnostic changes over the years. Table 2 showed the comparison of Asians in London with WHO data. One of the things that we haven't compared, is comparing schizophrenia with brief reactive psychosis, which we know is precipitated by crisis and has delusions of persecution and hallucinations and other cultural factors. Also when your compare broad schizophrenia among Asians, the rate was 3.46 in London and 3.5 in Chandigarh in north India and 3.2 in rural Changigarh. There are similarities in rates. But if you look at non-schizophrenic symptoms, there is a wide variation. These are people who have symptoms of schizophrenia, but they have not the core symptoms. Table 3 looked at life events in schizophrenia and their relationship, that is, separation from mother or father. If we look at 17% of whites with schizophrenia have been separated from their mother compared with 14% of Asians but 34% of African-Caribbeans. This separation is below the age of 11 for longer than four years. When you look at the separation from father, the results become even more stunning, that 34% of whites, only 14% of Asians and 53% of African-Caribbeans had been separated from their father for longer than four years. That is an indirect fact of migration. A father may have migrated but the children were being brought up in the Caribbean and that separation produces something. These are early findings and have subsequently indicated in a fairly large study of about 700 patients in London. The separation from father for more than four years still holds.

Table 2

Comparison of Asians in London with WHO data

	Broad Schizophrenia	Schizophrenia +	Non- Schizophrenia
Chandigarh - Rural	4.20	1.10	3.10
Chandigarh - Urban	3.50	0.90	2.60
Asians	3.46	2.02	0.80

Table 3

Life Events in Schizophrenia and their Relationship - Separation from mother or father

	Whites	Asians	African-Caribbeans	
MOTHER				
Yes	6 (17)	3 (14)	12 (34)	
No	29 (83)	18 (86)	23 (66)	$p = 0.152$
FATHER				
Yes	12 (34)	3 (14)	19 (53)	$X^2 = 8.61$
No	23 (66)	18 (86)	17 (47)	$df = 2$ $p = 0.013$

Four other hypotheses include, firstly, ethnic density. The second hypothesis on concepts of self, which is old-fashioned but very important to look at psycho-analytical notions of the self - "Who am I?" That's where cultural identity and the split between "who am I?" and "who do people see me as?" becomes very important. For patients that uncertainty, especially if there are organic changes in front and elsewhere, that becomes much more of a problem. Therefore the identity and the split of the self becomes very important.

Thirdly is achievement and aspiration. We studied five fields – education, employment, housing, financial and social standing. The single most important difference was discrepancy in housing. People felt that they would get better housing than they actually did, and that created some kind of stress on them.

Lastly is cultural congruity, which is related to ethnic density. People have looked at ethnic density for a number of years and several studies have indicated that ethnic density plays a role in schizophrenia. There have been two studies which have indicated that ethnic density does not play a role. I want to modify this hypothesis.

Cultural Considerations

Cultures are individualistic or collectivist, egocentric or social-centric culture, which is defined by Hofstead. Individualism refers to a society where the ties between individuals are very loose and everyone is expected to look after themselves or their immediate family. In this case immediate family is the nuclear family and not extended family. In a collectivist or social-centric culture, people from birth onwards are integrated into strong, cohesive groups which throughout their

lifetime continue to protect them in exchange for unquestioning loyalty. That's where notions about filial piety and kinship-based society come in because you are not much of an individual but part of a much bigger structure.

Individualism is to do with I-ness, I consciousness, my autonomy, my emotional independence, my initiative, my right to privacy , my pleasure-seeking, my financial security, my need for specific friendships. In collectivism it is We-ness. It's a collective identity, emotionally interdependent, group solidarity, sharing duties and obligations and need for stable and predetermined friendships and group decisions. If you are an individual who migrates, you are an egocentric or individualistic individual - I'll call it an egocentric individual - from a social-centric society migrating to an ego-centric society, you're more likely to fit in, especially if you don't have social-centric people from your society around you. If you're an ego-centric individual in an ego-centric society surrounded by social-centric people, you're more likely to have conflict with them. You want to be like the majority because you are like them, but your social-centric group of kinship is trying to hold you back. That culture conflict creates different kinds of problems.

The hypothesis is that if you are a social-centric individual from a social-centric society but are plonked in an ego-centric society and don't have social-centric individuals around you, you're more likely to feel alienated. That alienation will reflect in social isolation. It will reflect in your using drugs, especially if you're unemployed, and then part of that identity and a split shifts and changes things. That may lead you on to a road to schizophrenia or psychosis. If on the other hand you are an egocentric individual surrounded by social-centric people and you are caught in this culture conflict, there is evidence that you tend to harm yourself more, either take an overdose or cut yourself, partly to get time away, time out, from the social-centric individuals around you. Therefore the rates of deliberate self-harm are much higher.

I still remember immediately, when I moved to the U.K. I knew only two people in the whole country. Trying to meet people who were like-minded – and I don't mind admitting it here – one of the first things I did was to join a theatre group and appeared on stage. Interpret that any way you like. That was one way of meeting like-minded people, rather than saying, "I'll wait for people to come to me". You really have to go out and reach. In terms of pro tective factors, it is seeking out social support and interlinking with people who have similar world views and similar experiences that does help rather than locking yourself in.

The Case of Attempted Suicide

We did a series of studies in the late 90s in London looking at attempted suicide in different ethnic groups. Table 4 showed the rates of attempted suicide. For South Asian women the rates were 37.5 per thousand per year compared to white women, which was 23.3, black women which was 23.9, fairly similar, and other women at 30. On the other hand, South Asian men were lower than white men and about the same as black men. One possible explanation may be that their gender role expectations and gender role differ. We expect women to behave differently, especially in social-centric societies which are quite used to oppressing women. Yet, when you have migrated there is a problem that you expect women to do the household work like they have been doing in India. And yet you expect them to go and make money. When they come back the man would still expect his dinner on the table.

Table 4

Rates of Attempted Suicide

Ethnic Group	Population	Number	Rate/1000/year	CI
South Asian Women	17322	65	37.5	29-47.1
White Women	63528	148	23.3	19.7-27.4
Black Women	7089	17	23.9	13.9-38.4
Other	5641	17	30.1	17.6-48.2
South Asian Men	17196	24	13	8.9-20.8
White Men	61346	15	24.6	20.9-28.7
Black Men	6191	7	11.3	4.6-23.2
Other	5741	5	8.7	2.8-20.3

When we look back at age specific rates, the rates for South Asian women were 92.7 per thousand aged between 16 to 24, compared with 35.9 for white women so it's nearly 2.7 times higher. Black women and white women were fairly similar. Other groups were higher, but it's a hodge-podge of different ethnicity. South Asian men were less than 50% likely to attempt suicide compared to their white counterparts, and black men even lower than that. It's quite possible that South Asian men do deliberate self-harm by drinking. We know that the rates of alcoholic abuse among South Asian men are much higher. Is it that they are dealing with it in quite a different way? It's possible that these women aged 16 to 24 – the age when you are beginning to think about leaving home, having your own identity, having a job, forming your own relationships – and that's going to create more stress, if you're not being allowed by the social-centric people around you, who want you to behave like them when they were growing up. One of the tragedies of migration is that we as migrants think that the country that we have left behind has not changed at all. We have these memories and we behave the way the country was 15, 20, 30 years ago. Those values get superimposed on the children while they are saying something quite different. In this era of globalization there is further stress and tension.

Table 5

Age Specific Rates in Ethnic Groups

Age	16-24	25-34	35-44	45-54	55-64
South Asian Women	92.7	34.4	22.5	3.9	5.6
White Women	35.9	27.4	25.7	13.6	6.2
Black Women	37.1	33.4	25.6	0	0
Other	75.9	41.4	6.1	0	0
South Asian Men	12.4	20.2	17.3	3.8	9.9
White Men	30.2	28.1	30.1	19.9	7.8
Black Men	6.5	31.8	0	0	0
Other	7.9	12.1	12.7	0	0

The other study we did at the same time looking at inception rates of adolescents (Table 6). Among white males aged 10 to 14, the rate was 7.3 and among Asian males, it was 9. Among white females, it was 51 and Asian females 21. Up to aged 15, it starts to go up, becoming 127 in Asian females compared to 44 in white females. When adolescents are beginning to find their own identity, that may be one of the reasons that the rates are higher.

Table 6

Inception Rates in Adolescents

	White Male	White Female	Asian Male	Asian Female
10 - 14	3 4084 (7.3)	20 3859 (51)	3 2187 (9)	6 2737 (21)
15	5 796 (6.2)	7 1549 (44)	0	6 472 (127)
16 - 17	0	3 3015 (9)	0	

To conclude, illustrating from these two studies which I was heavily involved in, it's quite likely that the socio economic disadvantages play a role in psychiatric distress. Is it to do with their achievement and expectations? Is it to do with the fact that generally the migrants end up doing the jobs which nobody else wants to do and therefore have to work twice as hard? Is it to do with racial discrimination, by virtue of your skin colour or religion or something that you constantly get prejudice against you and that causes a loss of self-esteem? Whether that loss of self-esteem leads to split of the self, leading to schizophrenia or that loss of self-esteem leads to some kind of sub-clinical depression and deliberate self harm is anybody's guess.

Is it that there are biological factors related to specific ethnicities which produce a grevious disposition to migration and to certain psychiatric disorders? Probably not. Obviously premorbid personality in any psychiatric disorder will play a key role. One of the interesting things that we found in the schizophrenia study was a significant proportion of people had tried to change their religion within six months of their contact with psychiatric services. Maybe that is the time that they are trying to find some kind of stability, that something is happening, the self is being pulled in different directions. They're trying to find some kind of anchor to respond and to deal with that. Cultural and self-identity becomes incredibly important. I already touched upon achievement and expectations. The social networks goes back to cultural congruity. Wherever I am staying, if there are people who are like-minded, whatever their ethnicity, I am more likely to be accepted and I am more likely to accept them. Or, if I am surrounded by people who have a very different world, who have very different notions, who have very different ways of eating and dressing and speaking on a day to day basis, would that cause more distress and stress on me? It's anybody's guess again.

摘要

移民與精神健康

本文論述由移民衍生的壓力，對個人及家庭均有影響。文中並引用學術研究資料，探討移民與精神分裂症及自殺的關係，強調了解文化因素對分析上述精神問題的重要性。香港是一個擁有大量移民者的地方，本文對於香港的有關研究具有參考價值。

Reference

Ødegaard,Ø. (1932). Emigration and insanity. *Acta Psychiatrica Scandinavica* Suppl. 4.